VENOM EXTRACT PRESCRIPTION

1. DATE ORDERED	2. PRESCRIPTION NO.

3. FORWARD REQUEST TO *(X and complete as applicable)*

- ☐ a. U.S. Army Allergen Extract Laboratory, WRAMC, Washington, DC 20307-5001
- ☐ b. Other Laboratory *(List name and complete mailing address)*

4. TO ORDER DIAGNOSTIC KIT, X HERE → ☐

Add 1.2 ml HSA to 12 mcg vial. Label as 10 mgc/ml. Shake. Continue with serial dilutions described in Item 9.

5. TYPE VENOM* *(X only one per form)*

☐	a. Honey Bee	☐	d. Yellow Jacket
☐	b. Wasp	☐	e. White-Faced Hornet
☐	c. Yellow Hornet	☐	f. Mixed Vespid**

6. THIS TREATMENT PROGRAM MAY BE CONTINUED WITHOUT RE-EVALUATION UNTIL *(Enter date) (36 months maximum)*

7. IS THIS PRESCRIPTION A REFILL? *(X one)*

- ☐ a. YES *(If Yes, where is the patient receiving treatment?)*
- ☐ b. NO

NOTES: * If more than one Hymenoptera-order venom is indicated, the different preparations shall be administered by separate injections according to the schedule on the back of the form.

** The Mixed Vespid preparation may be substituted for individual venoms only if the patient is allergic to all three of the following venoms: Yellow Jacket, Yellow Hornet, and White-Faced Hornet. Note that its total concentration is triple that of each component.

8. RECONSTITUTION INSTRUCTIONS

a. Read the freeze-dried venom vial label to determine the microgram (mcg) content.

b. Use proper diluent: Human Serum Albumin 0.03% in 0.9% NaCl & 0.4% Phenol (HSA).

c. For 100 mcg vials, add 1.2 ml HSA to Venom Powder. Label contents 100 mcg/ml. Shake.

d. For 550 mcg vials, add 5.5 ml HSA to Venom Powder. Label contents 100 mcg/ml. Shake.

e. For 1.1 mg vials, add 11 ml HSA to Venom Powder. Label contents 100 mcg/ml. Shake.

f. Proceed with ten-fold serial dilutions as described in item 9.

NOTE: Mixed Vespid products contain triple the amount of TOTAL protein (100 mcg/ml of each venom component, or 300 mcg/ml total). Add diluent as directed by the vial label.

9. DILUTION INSTRUCTIONS

a. Add 0.2 ml of 100 mcg/ml Vial to 1.8 ml HSA. Label as 10.0 mcg/ml. Shake well.

b. Add 0.2 ml of 10 mcg/ml Vial to 1.8 ml HSA. Label as 1.0 mcg/ml. Shake well.

c. Add 0.2 ml of 1.0 mcg/ml Vial to 1.8 ml HSA. Label as 0.1 mcg/ml. Shake well.

d. Add 0.2 ml of 0.1 mcg/ml Vial to 1.8 ml HSA. Label as 0.01 mcg/ml. Shake well.

e. Add 0.2 ml of 0.01 mcg/ml Vial to 1.8 ml HSA. Label as 0.001 mcg/ml. Shake well.

10. STORAGE AND STABILITY INSTRUCTIONS

a. STORAGE. Store all freeze-dried and reconstituted venom products under refrigeration at 2 - 7° C (36 - 45° F).

b. STABILITY. Stability after time of reconstitution is listed in Item 16.

11. SPECIFIC INSTRUCTIONS

A physician must always be IMMEDIATELY available with emergency equipment. If the injections cause repeated reactions or are suspected of causing delayed symptoms repeatedly, or if reactions prevent progression of treatment, contact the originating medical facility for further instructions, or the Consultant of the Day, Allergy Clinic, WRAMC. If any patient on maintenance therapy is stung and experiences systemic symptoms of sensitivity, contact the originating medical facility or Allergy Clinic, WRAMC (AV 291-1850).

12. MEDICAL FACILITY

a. NAME

b. ADDRESS *(Include Zip Code)*

c. PHONE NO. *(Autovon & Commercial)*

13. PRESCRIBER

a. PRINTED NAME/STAMP

b. PERSONAL SIGNATURE

14. SEND VENOM TO

15. PATIENT DATA

a. PATIENT'S NAME *(Last, First, Middle Initial)*

b. SEX

16. PATIENT'S IDENTIFICATION *(Use this space for mechanical imprint)*

c. HOME ADDRESS *(Street, City, State and Zip Code)*

d. PHONE NO. *(Include Area Code)*

e. YEAR OF BIRTH

f. RELATIONSHIP TO SPONSOR

g. COMPONENT/STATUS

h. DEPART/SERVICE

i. SPONSOR'S NAME

j. RANK/GRADE

k. SSN OR IDENTIFICATION NUMBER

l. ORGANIZATION

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17. RECOMMENDED VENOM TREATMENT SCHEDULE

DOSE	DOSE VOLUME	CONCENTRATION	COMMENTS
WEEK 1 (a)	0.05 ml	0.001 mcg/ml	STABILITY: only 24 hours
(b)	0.10	0.001	
(c)	0.50	0.001	Doses (a), (b), (c) given 30 minutes apart
WEEK 2 (a)	0.05 ml	0.01 mcg/ml	STABILITY: only 24 hours
(b)	0.10	0.01	
(c)	0.50	0.01	Doses (a), (b), (c) given 30 minutes apart
WEEK 3 (a)	0.05 ml	0.1 mcg/ml	STABILITY: only 14 days
(b)	0.10	0.1	
(c)	0.50	0.1	Doses (a), (b), (c) given 30 minutes apart
WEEK 4	0.05 ml	1.0 mcg/ml	STABILITY: only 30 days
WEEK 5	0.10	1.0	
WEEK 6	0.20	1.0	
WEEK 7	0.40	1.0	
WEEK 8	0.05 ml	10 mcg/ml	STABILITY: only 30 days
WEEK 9	0.10	10	
WEEK 10	0.20	10	
WEEK 11	0.40	10	
WEEK 12	0.05 ml	100 mcg/ml	STABILITY: 365 days (12 months) after reconstitution
WEEK 13	0.10	100	
WEEK 14	0.20	100	
WEEK 15	0.40	100	Dosage volumes may be divided into two or more injection sites.
WEEK 16	0.60 ml	100 mcg/ml	
WEEK 17	0.80	100	
WEEK 18	1.00	100	
WEEK 19	1.00	100	
WEEK 20	1.00	100	
WEEK 21	1.00 ml	100 mcg/ml	
WEEK 23	1.00	100	
WEEK 26	1.00	100	
WEEK 30 and	1.00	100	
Every 4 - Weeks	1.00 ml	100 mcg/ml	

NOTES: REFILLS. Do not reduce dosage when administering venom from a new refill vial.

MIXED VESPID PRODUCTS. Give the SAME VOLUME FOR EACH INJECTION listed above. *(The concentration listed above indicates each of the three component venoms present. Total venom concentration (example: 300 mcg/ml) is triple the amount listed.)*

18. DETAILED INSTRUCTIONS FOR EVERY INJECTION

a. A physician must be **immediately** available and equipped to deal with emergencies.

b. ALL PATIENTS MUST REMAIN IN CLINIC AT LEAST 30 - 60 MINUTES AFTER AN INJECTION.

c. Use 26 - 28g needle. Inject subcutaneously into (fatty) outer aspect of upper arm.

d. Record date, dosage, and reactions on Hyposensitization Record and on separate form, such as SF 600, SF 509, or other prescribed form.

e. GRADING AND MANAGEMENT OF REACTIONS:
(1) Negative (Swelling up to 15 mm): progress according to schedule above.
(2) "A" (Swelling 15 - 20 mm): repeat previous dose.
(3) "B" (Swelling 20 - 25 mm): return to previous dose where no reaction occurred.
(4) "C" (Swelling over 25 mm or persisting over 12 hours) and systemic reactions: Consult with prescribing allergist without delay.

f. MISSED DOSES: *(prior to maintenance)*
(1) 1 - 2 weeks: repeat last dose:
(2) 3 or 4 weeks: reduce dose by 25% or 50%;
(3) more than 4 weeks: contact allergist before proceeding;
(4) *(While at maintenance dose)* decrease 25% for each week delayed after scheduled dose. Contact allergist with all other questions.

19. REMARKS AND/OR MODIFICATIONS TO TREATMENT SCHEDULE

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